

**PARENTAL AUTHORIZATION FOR USE OF OVER-THE-COUNTER MEDICATION,  
NOTIFICATION OF CHILD'S ALLERGIES, and CURRENT MEDICATIONS**

My child, \_\_\_\_\_, has no known allergies.

My child, \_\_\_\_\_, is allergic to the following (e.g.,  
medications, foods, insect bites, etc.):

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You have my permission to give my child the following over-the-counter medications, as  
needed, for ailments such as headache, fever, stomach cramps, sinus congestion, upset stomach,  
etc. Please check the medications that your child is allowed to have:

\_\_\_\_\_ Benadryl or generic equivalent

\_\_\_\_\_ Ibuprofen (Motrin)

\_\_\_\_\_ Acetaminophen (Tylenol)

\_\_\_\_\_ Neosporin or generic equivalent (topical antibiotic)

\_\_\_\_\_ Pepto-Bismol or generic equivalent

\_\_\_\_\_ Sudafed or available replacement

\_\_\_\_\_ Roloids or generic equivalent

\_\_\_\_\_ Cough syrup

Comments:

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My child is currently taking the following medications. Please list the medications and their  
purpose.

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Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_